SAFE Medicine®
Protect Yourself from Medication Errors
The Institute for Safe Medication Practices
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Doctor's offices are not child-proof

If you have young children or grandchildren, you are probably used to being on the lookout for danger in your home and the child's play areas. But a doctor's office or clinic might be an unrecognized source of danger, as one mother learned.

The mother had an appointment with her doctor to have a small tube placed in her ear to promote healing after an ear infection. When she arrived, her 3-year-old child was allowed to go with her into the exam room along with another family member who was supposed to be watching him. The doctor had gathered his supplies, including a cup of phenol, and placed them on the counter. Phenol is a strong chemical that the doctor was going to use to numb the mother's eardrum. In the blink of an eye, the child was able to grab a cup of phenol off the counter and try to drink it. The chemical spilled down the front of the child's face and chest. He had immediate pain and irritation to his lips, chest, and abdomen. The doctor quickly flushed the involved areas with water and sent the child to a nearby children's hospital. The child was treated for rather severe chemical burns. He also had to undergo two procedures to make sure there was no damage to his throat and breathing passages.

Nurses and doctors typically keep chemicals and medicines locked and out of reach until they are needed. But once these products are removed from a cabinet right before they are needed, children may be able to get them. Thus, it would be safer to find someone to watch a child at home or in the waiting room rather than bring them with you into an exam room. Parents also need to watch their children carefully when visiting the pediatrician's office or hospitals, too. Similar hazards exist there, although doctors and nurses who treat children may have taken additional precautions to keep children safe.

*nice*catch

Omacor (omega-3-acid ethyl esters) is a new medicine for people with very high triglycerides (a storage form of fat in the blood). The drug is also being studied in patients who have had a heart attack to see if it reduces the risk of more heart attacks. Unfortunately, Omacor looks and sounds very similar to another medicine, Amicar (aminocaproic acid). Amicar is used to treat severe bleeding in people with conditions that cause blood clots to dissolve faster than normal. Both medicines come in 1 gram dosages and may be prescribed for patients with heart trouble. When a doctor called the pharmacy to prescribe Omacor for his patient, a pharmacist misheard the drug name as Amicar. Fortunately, the patient read the drug information sheet that came with his prescription and called the pharmacist to let him know he was expecting a medicine to reduce his triglycerides, not to treat bleeding. If he had taken the Amicar, he may have developed blood clots. Always read the information sheet that comes with your medicine.

Brand name medicines appear in green; generic medicines appear in red.

60 second safety tip

■ **One nostril or two?** Some medicines come as a nasal spray. While a spray in each nostril is the typical way to take a single dose, there are some exceptions. Some medicines are meant to be given as a single spray into one nostril for each dose. One prime example is calcitonin salmon (Fortical or Micalcin), a medicine used to treat women with osteoporosis (bone thinning) after menopause. A single spray of this medicine into one nostril delivers the full dose. (Spraying the medicine into the opposite nostril the next day is recommended.) Several medicines used to treat migraine headaches also come as nasal sprays intended to be sprayed into just one nostril, including Imitrex (sumatriptan) and Zomig (zolmitriptan).

Some people have given themselves double doses by spraying these medicines into both nostrils. Sometimes, patients have forgotten their doctors' instructions to use a single spray of the medicine. Other times, the pharmacy has applied a label on the medicine container with the wrong directions to deliver a spray into each nostril. This happens if the computer in the pharmacy has been set up to automatically print labels for nasal sprays with the more common directions: "spray in each nostril." So, don't assume that any nasal spray you use is supposed to be sprayed into both nostrils. Ask your doctor or pharmacist to be certain you understand the directions for use.

A rainbow of colors for wristbands

Many organizations offer a small colored wristband to people who want to show their support for a particular cause. For example, many people are familiar with the yellow Livestrong bracelet to support bicyclist Lance Armstrong's foundation to fight cancer. There are light blue bracelets to support Hemophilia, aqua ones for the Special Olympics, blue and white marble bracelets to support Katrina victims, and the list goes on. Now, because there are so many colors, you may not know what the bracelet means. Unfortunately, the same thing happens in hospitals.

Hospitals often use color-coded bracelets to signal important information such as allergies, treatment preferences, particular medicines the patient is taking, and so on. A survey conducted in Pennsylvania found that four out of five hospitals, surgery centers, and birthing centers in that state use these color-coded patient wristbands. However, the potential for confusion is great. The survey identified 22 different types of information that may be communicated by a rainbow of different colors. The problem is, there are no standard colors assigned to signal their meaning consistently, and some facilities don't use colored bracelets at all. So new nurses and doctors who have worked at another facility could confuse their meaning, as could medical staff who are caring for a patient who was transferred from another facility with a bracelet in place.

It can mean trouble for a person when a bracelet is confused for something else, especially in the hospital. One hospitalized patient was given a green bracelet to wear. At this hospital, it meant that he was severely allergic to latex, a substance used in some medical supplies such as gloves and medicine containers. During his hospital stay, he was transported to a clinic for a test. Doctors and nurses at the clinic thought that green bracelets signaled that the arm on which it was applied was not to be used to take blood samples. They then performed the test using medical supplies that contained latex. The patient experienced a severe allergic reaction and required extra medical treatment to correct the situation.

To help protect yourself from confusion with colored medical bracelets:

- Remove your personal colored bracelet(s) if you are going to the hospital or to a clinic for tests. You do not want it being confused for a bracelet with a different meaning.
- If colored medical bracelets are placed on you, find out their meaning. This way you can speak up to help the nurses and doctors understand its meaning.

Reference: PA Patient Safety Authority. Use of color-coded patient wristbands creates unnecessary risk. Supplementary Advisory. December 14, 2005; Available: www.psa.state.pa.us/psa/lib/psa/advisories/v2_s2_sup_advisory_dec_14_2005.pdf. Accessed July 18, 2006.

Be part of the safety team

Two years ago, a Florida judge ruled that parents have a duty to read the drug information sheets that are given out with prescriptions for their children. The ruling was in response to a case involving a 3-month-old infant with an infection in her mouth (thrush). The baby's doctor had prescribed liquid nystatin to treat the infection. By mistake, the pharmacy dispensed a cold medicine containing a decongestant and an antihistamine. The pharmacy had provided a drug information sheet for the cold medicine. However, the mother never read it before she gave her baby the medicine.

The baby's infection worsened because the right medicine was not given. The baby's doctor discovered the error during the next office visit. The mother sued the pharmacy. The judge clearly recognized that the pharmacist had a responsibility to fill the prescription correctly. However, he also ruled that the mother had an equal responsibility to read the drug information sheet. If she had, she may have known it was the wrong medicine.

The judge's ruling in this case may seem harsh. However, it brings an important point to light. The information given to you with your prescription is important. It tells you why the medicine is used, its side effects, foods that shouldn't be eaten with the medicine, and other helpful information. Please take the time to read it.

Contact Information

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